FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040394

Facility Name: GLENWOOD CARE CENTER

Address: 222 N. HAMMES (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3873066

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,298	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,298	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,933	2,933	8
9	SNF/PED					9
10	ICF	44,913	4,806	474	50,193	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,913	4,806	3,407	53,126	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 71.50%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 2933

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	180,083	17,832	6,085	204,000		204,000	3,736	207,736			1
2	Food Purchase		224,259		224,259	(21,082)	203,177	(987)	202,190			2
3	Housekeeping	189,920	28,899	0	218,819		218,819	0	218,819			3
4	Laundry	57,233	18,294	0	75,527		75,527	0	75,527			4
5	Heat and Other Utilities			122,165	122,165		122,165	438	122,603			5
6	Maintenance	49,508	27,933	45,191	122,632		122,632	10,714	133,346			6
7	Other (specify):*			19,144	19,144		19,144	0	19,144			7
8	**TOTAL General Services**	476,744	317,217	192,585	986,546	(21,082)	965,464	13,901	979,365			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000	0	4,000			9
10	Nursing and Medical Records	1,555,007	103,431	2,596	1,661,034		1,661,034	25,342	1,686,376			10
10a	Therapy	83,267	13,357	33,593	130,217		130,217	(3,956)	126,261			10a
11	Activities	71,700	5,441	0	77,141		77,141	0	77,141			11
12	Social Services	89,966		2,938	92,904		92,904	0	92,904			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,799,940	122,229	43,127	1,965,296		1,965,296	21,386	1,986,682			16
	C. General Administration											
17	Administrative	92,776		202,000	294,776		294,776	(101,024)	193,752			17
18	Directors Fees			0				0				18
19	Professional Services			204,636	204,636		204,636	(153,799)	50,837			19
20	Dues, Fees, Subscriptions & Promotions			45,405	45,405		45,405	(2,067)	43,338			20
21	Clerical & General Office Expense	66,400	20,871	128,628	215,899		215,899	(33,697)	182,202			21
22	Employee Benefits & Payroll Taxes			358,384	358,384	21,082	379,466	0	379,466			22
23	Inservice Training & Education			2,325	2,325		2,325	1,028	3,353			23
24	Travel and Seminar			0				114	114			24
25	Other Admin. Staff Transportation			4,428	4,428		4,428	1,298	5,726			25
26	Insurance-Prop.Liab.Malpractice			91,907	91,907		91,907	3,859	95,766			26
27	Other (specify):*			0				26,868	26,868			27
28	**TOTAL General Administration**	159,176	20,871	1,037,713	1,217,760	21,082	1,238,842	(257,420)	981,422			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,435,860	460,317	1,273,425	4,169,602		4,169,602	(222,133)	3,947,469			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,892	28,892		28,892	1,643	30,535			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			49,515	49,515		49,515	850	50,365			32
33	Real Estate Taxes			79,135	79,135		79,135	0	79,135			33
34	Rent-Facility & Grounds			1,076,230	1,076,230		1,076,230	5,838	1,082,068			34
35	Rent-Equipment & Vehicles			41,459	41,459		41,459	(12,075)	29,384			35
36	Other (specify):*							0				36
37	TOTAL Ownership			1,275,231	1,275,231		1,275,231	(3,744)	1,271,487			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		96,880	104,851	201,731		201,731	(30,804)	170,927			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			111,448	111,448		111,448	0	111,448			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		96,880	216,299	313,179		313,179	(30,804)	282,375			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,435,860	557,197	2,764,955	5,758,012	0	5,758,012	(256,681)	5,501,331			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(7,918)	30		9
10	Interest and Other Investment Income	(85)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(987)	2		13
14	Non-Care Related Interest	(24)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(280)	20		17
18	Fines and Penalties	(5,494)	21		18
19	Entertainment	0	20		19
20	Contributions	(165)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(2,812)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(57)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(1,878)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (19,700)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(236,981)	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (236,981)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (256,681)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS **Page 5A**

Facility Name GLENWOOD CARE CENTER

IDPH 0808394

Report Period Beginning: 01/01/2008

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G43 is from Page 5.				**Line 1**	0
1	**Day Care**	0	0	**Line 2**	(987)
2	**Other Care for Outpatients**	0	0	**Line 3**	0
3	**Governmental Sponsored Special Programs**	0	0	**Line 4**	0
4	**Non-Patient Meals**	0	2	**Line 5**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 6**	(1,878)
6	**Rented Facility Space**	0	34	**Line 7**	0
7	**Sale of Supplies to Non-Patients**	0	10	**Line 8**	(2,865)
8	**Laundry for Non-Patients**	0	4	**Line 9**	0
9	**Non-Straightline Depreciation**	(7,918)	30	**Line 10**	0
10	**Interest and Other Investment Income**	(85)	32	**Line 10a**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 11**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 12**	0
13	**Sales Tax**	(987)	2	**Line 13**	0
14	**Non-Care Related Interest**	(24)	32	**Line 14**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 15**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 16**	0
17	**Non-Care Related Fees**	(200)	20	**Line 17**	0
18	**Fines and Penalties**	(5,494)	21	**Line 18**	0
19	**Entertainment**	0	20	**Line 19**	0
20	**Contributions**	(165)	20	**Line 20**	(5,214)
21	**Owner or Key-Man Insurance**	0	22	**Line 21**	(5,494)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 22**	0
23	**Malpractice Insurance for Individuals**	0	26	**Line 23**	0
24	**Bad Debt**	0	27	**Line 24**	0
25	**Fund Raising, Advertising and Promotional**	(2,812)	20	**Line 25**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 26**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 27**	0
28	**Yellow Page Advertising**	(57)	20	**Line 28**	(8,909)
29	**Non-Paid Workers**	0	0	**Line 29**	(13,847)
30	**Donated Goods**	0	0	**Line 30**	(7,918)
31	**Amortization Expense**	0	0	**Line 31**	0
32	Deferred Maintenance SIX-H	(1,878)	6	**Line 32**	(180)
33				**Line 33**	0
34				**Line 34**	0
35				**Line 35**	0
36				**Line 36**	0
37				**Line 37**	(8,927)
38				**Line 38**	0
39				**Line 39**	0
40				**Line 40**	0
41				**Line 41**	0
42				**Line 42**	0
43				**Line 43**	0
44				**Line 44**	0
45				**Line 45**	(19,709)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	3,736	0	0	0	0	0	0	0	0	0	3,736	1
2	Food Purchase	(987)	0	0	0	0	0	0	0	0	0	0	(987)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	438	0	0	0	0	0	0	0	0	0	438	5
6	Maintenance	(1,878)	12,592	0	0	0	0	0	0	0	0	0	10,714	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,865)	16,766	0	0	0	0	0	0	0	0	0	13,901	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	25,342	0	0	0	0	0	0	0	0	0	25,342	10
10a	Therapy	0	6,775	(10,731)	0	0	0	0	0	0	0	0	(3,956)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	32,117	(10,731)	0	0	0	0	0	0	0	0	21,386	16
	C. General Administration													
17	Administrative	0	(101,024)	0	0	0	0	0	0	0	0	0	(101,024)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(153,799)	0	0	0	0	0	0	0	0	0	(153,799)	19
20	Fees, Subscriptions & Promotions	(3,314)	0	1,247	0	0	0	0	0	0	0	0	(2,067)	20
21	Clerical & General Office Expenses	(5,494)	(89,320)	61,117	0	0	0	0	0	0	0	0	(33,697)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,028	0	0	0	0	0	0	0	0	1,028	23
24	Travel and Seminar	0	0	114	0	0	0	0	0	0	0	0	114	24
25	Other Admin. Staff Transportation	0	0	1,298	0	0	0	0	0	0	0	0	1,298	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,859	0	0	0	0	0	0	0	0	3,859	26
27	Other (specify):*	0	0	26,868	0	0	0	0	0	0	0	0	26,868	27
28	**TOTAL General Administration**	(8,808)	(344,143)	95,531	0	0	0	0	0	0	0	0	(257,420)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,673)	(295,260)	84,800	0	0	0	0	0	0	0	0	(222,133)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,918)	0	9,561	0	0	0	0	0	0	0	0	1,643	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(109)	0	959	0	0	0	0	0	0	0	0	850	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,838	0	0	0	0	0	0	0	0	5,838	34
35	Rent-Equipment & Vehicles	0	0	(12,075)	0	0	0	0	0	0	0	0	(12,075)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,027)	0	4,283	0	0	0	0	0	0	0	0	(3,744)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(30,804)	0	0	0	0	0	0	0	0	(30,804)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	(30,804)	0	0	0	0	0	0	0	0	(30,804)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(19,700)	(295,260)	58,279	0	0	0	0	0	0	0	0	(256,681)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe GLENWOOD CARE CENTER # 0040294 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6I | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	Amount	4	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	17 MANAGEMENT FEES	154,000		CAREPLUS MGMT INC	0	0	(154,000)	1	-154000
2	V	19 ADMIN. CONSULTANT FEES	148,500		" "			(148,500)	2	-148500
3	V	19 DATA PROCESSING FEES	8,800		" "			(8,800)	3	-8800
4	V	21 CLERICAL FEES	89,220		" "			(89,220)	4	-89320
5	V	1 DIETARY CONSULTANT FEE	5,500		" "			(5,500)	5	-5500
6	V	1 DIETARY SALARIES			" "		9,236	9,236	6	9236
7	V	5 ELECTRICITY			" "		438	438	7	438
8	V	6 REPAIRS			" "		774	774	8	774
9	V	6 MAINTENANCE SALARIES			" "		11,818	11,818	9	11818
10	V	10 NURSING			" "		25,342	25,342	10	25342
11	V	10a THERAPY SALARIES			" "		6,775	6,775	11	6775
12	V	17 ADMIN SALARIES			" "		52,976	52,976	12	52976
13	V	19 PROFESSIONAL FEES			" "		3,501	3,501	13	3501
14	Total		$ 406,120			$	110,864	$ * (295,256)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	10A	THERAPY SERVICES	$ 36,525	CAREPLUS REHABILITATIVE SERVICES		$ 25,794	$ (10,731)	15	-10731
16	V	39	ANCILLARY THERAPY	104,850	" "		74,046	(30,804)	16	-30804
17	V								17	
18	V								18	
19	V	20	DUES/LICENSES/WANT ADS		CAREPLUS MGMT INC		1,247	1,247	19	1247
20	V	21	OFFICE SALARIES/EXPENSES		" "		61,117	61,117	20	61117
21	V	23	SEMINARS		" "		1,028	1,028	21	1028
22	V	24	TRAVEL		" "		114	114	22	114
23	V	25	TRANSPORTATION		" "		1,298	1,298	23	1298
24	V	26	INSURANCE		" "		3,859	3,859	24	3859
25	V	27	EMPLOYEE BENEFITS		" "		26,868	26,868	25	26868
26	V	30	SL DEPRECIATION		" "		9,561	9,561	26	9561
27	V	32	INTEREST		" "		959	959	27	959
28	V	34	OFFICE RENT		" "		5,838	5,838	28	5838
29	V	35	EQUIP RENT/AUTO LEASE	19,362	" "		7,287	(12,075)	29	-12075
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 160,737			$ 219,016	$ * 58,279	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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Print Page 6C

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Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6D

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STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

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Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN.FINAN(	22.33	SEE ATTACHED	4.9	8.19	SALARY	15,152	17-7	2
3	JAKOB BAKST	DIR OPERATION	ADMIN,CONSU	22.33	SCHEDULE	4.9	8.19	" "	15,152	17-7	3
4	JOE ZIMMERMAN	CFO	CLERICAL	0.98		4.9	8.19	" "	8,888	21-7	4
5	JANICE L. CLAFFORD	CONTROLLER	CLERICAL	0.98		4.9	8.19	" "	3,024	21-7	5
6	ROMY MACASAET	RN CONSULTANT	NURSING	0.49		4.9	8.19	" "	6,903	10-7	6
7	JAMEE O'BRIEN	REGIONAL DIR	ADMINISTRAT	0.49		4.9	8.19	" "	8,069	17-7	7
8	MOSHE POLLAK	DIR OF MAINT	MAINTEN	0.49		4.9	8.19	" "	5,441	6-7	8
9	TAMMY ORR	RN CONSULTAN	NURSING	0.49		4.9	8.19	" "	7,301	10-7	9
10	JOE ANN BREW	REGIONAL DIR	ADMINISTRAT	0.49		4.9	8.19	" "	4,650	17-7	10
11	NORA K. GORMAN	ADMINISTRATO	ADMINISTRAT	0.49		48	100	" "	60,597	17-1	11
12	ERIC ROTHNER (HUNTER MGMT LLC)		CONSULTANT	45.812		0.29	0.5	MGMT FEES	48,000	17-3	12
13								TOTAL	$ 183,177		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	559,284	11	$ 97,227	$ 97,227	53,126	$ 9,236	1
2	5	ELECTRICITY	" "	648,651	14	5,352		53,126	438	2
3	6	REPAIRS	" "	648,651	14	9,448		53,126	774	3
4	6	MAINTENANCE SALARIES	" "	648,651	14	144,297	144,297	53,126	11,818	4
5	10	NURSING	" "	648,651	14	309,417	309,417	53,126	25,342	5
6	10a	THERAPY SALARIES	" "	578,314	12	73,756	73,756	53,126	6,775	6
7	17	ADMIN SALARIES	" "	648,651	14	646,825	646,825	53,126	52,976	7
8	19	PROFESSIONAL FEES	" "	648,651	14	42,748		53,126	3,501	8
9	20	DUES/LICENSES/WANT AD	" "	648,651	14	15,220		53,126	1,247	9
10	21	OFFICE SALARIES/EXPEN	" "	648,651	14	746,225	559,379	53,126	61,117	10
11	23	SEMINARS	" "	648,651	14	12,554		53,126	1,028	11
12	24	TRAVEL	" "	648,651	14	1,390		53,126	114	12
13	25	TRANSPORTATION	" "	648,651	14	15,846		53,126	1,298	13
14	26	INSURANCE	" "	648,651	14	47,123		53,126	3,859	14
15	27	EMPLOYEE BENEFITS	" "	648,651	14	328,053		53,126	26,868	15
16	30	SL DEPRECIATION	" "	648,651	14	116,734		53,126	9,561	16
17	32	INTEREST	" "	648,651	14	11,707		53,126	959	17
18	34	OFFICE RENT	" "	648,651	14	71,276		53,126	5,838	18
19	35	EQUIP RENT/AUTO LEASE	" "	648,651	14	88,968		53,126	7,287	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,784,166	$ 1,830,901		$ 230,036	25

Print Preview

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Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	CAREPLUS MANAGEMENT ALLOCATION										959	5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	04/95	1,300,000	451,000		PRIME+	49,006	6
7	FIRST PREMIUM		X	INSURANCE FINANCE							485	7
8												8
9	TOTAL Facility Related						$ 1,300,000	$ 451,000			$ 50,450	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE PAYMENTS							24	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 24	14
15	TOTALS (line 9+line14)						$ 1,300,000	$ 451,000			$ 50,474	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	72,750	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	75,565	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,815	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	76,320	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	79,135	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	74,645	8
	1996	70,445	9
	1997	71,803	10
	1998	72,032	11
	1999	75,565	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	75,625		$	1
2					2
3	TOTALS	75,625		$ 0	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	LEASEHOLD IMPROVEMENTS			1993	1,080	34	31.5	34		262	9
10	LEASEHOLD IMPROVEMENTS			1993	26,757	686	39	686		5,107	10
11	LEASEHOLD IMPROVEMENTS			1994	4,980	128	39	128		869	11
12	OUTLETS			1995	1,429	37	39	37		196	12
13	PAVING			1995	19,500	1,301	15	1,301		7,154	13
14	ROOF REPAIR			1996	2,505	64	39	64		312	14
15	ELEVATOR REPAIR			1996	7,000	179	39	179		858	15
16	WATER CONDITIONING SYSTEM			1996	3,486	89	39	89		419	16
17	ROOFTOP A/C UNIT			1996	5,300	136	39	136		550	17
18	LANDSCAPING			1996	3,554	237	15	237		1,066	18
19	EXTERIOR PLASTER/PAINT			1997	8,500	218	39	218		827	19
20	PLUMBING			1997	1,091	28	39	28		102	20
21	LAMINATED COUNTER TOPS			1997	5,900	152	39	152		481	21
22	WALK-IN COOLER			1998	9,893	254	39	254		751	22
23	OUTDOOR STORAGE UNIT			1998	1,200	31	39	31		89	23
24	DRAIN LINE REPAIRS			1998	6,575	168	39	169	1	467	24
25	ROOFTOP HEAT / AC UNIT			1998	5,200	133	39	133		294	25
26	LANDSCAPING			1998	5,883	392	15	392		980	26
27	ROOF & HEATING REPAIRS / FIRE SAFETY UPGRADE			1999	17,798	456	39	456		538	27
28	NEW SUSPENDED CELLING			2000	64,670	1,967	27.5	1,967		1,967	28
29	CARPET-ENTRANCE & LOBBY			2000	2,750	98	20	138	40	138	29
30											30
31											31
32											32
33	CAREPLUS MGMT INC:										33
34	LEASEHOLD IMPROVEMENTS					87		87			34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 6,875		$ 6,916	$ 41	$ 23,427	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 155,491	$ 20,940	$ 13,159	$ (7,781)	8-15 YR	$ 53,386	37
38	Current Year Purchases	24,408	1,164	986	(178)	10-15 YR	986	38
39	Fully Depreciated Assets							39
40	RELATED PARTY-ALLOC SL DEPR		9,474	9,474				40
41	TOTALS	$ 179,899	$ 31,578	$ 23,619	$ (7,959)		$ 54,372	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 38,453	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 30,535	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (7,918)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 77,799	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: METROPOLITAN NURSING CENTER OF JOLIET
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1970	203	04/01/93	$ 1,076,230	30		3
4	Additions							4
5								5
6								6
7	TOTAL		203		$ 1,076,230 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 04/01/93
Ending 03/31/23

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/01	$ #######
13.	12/31/02	$ #######
14.	12/31/03	$ #######

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipm $ 33,009 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ 650.00	$ 8,450	17
18					18
19					19
20					20
21	TOTAL		$ 650.00	$ 8,450	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 44,370	$		$ 44,370	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				108			108	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				60,373			60,373	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					74,616		74,616	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program	39-2						3,840		3,840	12
13	MEDICAL SUPLIES Other (specify): LABS/RENTALS	39-2 39-2						9,239 9,185		9,239 9,185	13
14	TOTAL				$		$ 104,851	$ 96,880		$ 201,731	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (474,744)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,253,790		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,561		6
7	Other Prepaid Expenses	1,147		7
8	Accounts Receivable (owners or related parties)	57,500		8
9	Other(specify): REAL ESTATE TAX ESCROW	77,025		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 951,279	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	205,051		15
16	Equipment, at Historical Cost	179,899		16
17	Accumulated Depreciation (book methods)	(134,256)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	487,200		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DUE FROM BUILDING LLC	33,510		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 771,404	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,722,683	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 273,334	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,460		28
29	Short-Term Notes Payable	468,725		29
30	Accrued Salaries Payable	114,712		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,973		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,320		32
33	Accrued Interest Payable	162		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 946,686	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 946,686	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 775,997	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,722,683	$	48

***(See instructions.)**

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Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 790,490	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(22,890)	3
4	IL REPLACEMENT TAX	(7,347)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 760,253	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	76,644	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(60,900)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 15,744	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 775,997	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,824,870	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,824,870	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	9,701	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,701	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	85	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 85	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**DISCOUNTS**		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 5,834,656	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 986,546	31
32	Health Care	1,965,296	32
33	General Administration	1,217,760	33
	B. Capital Expense		
34	Ownership	1,275,231	34
	C. Ancillary Expense		
35	Special Cost Centers	201,731	35
36	Provider Participation Fee	111,448	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,758,012	40
41	**Income before Income Taxes (line 30 minus line 40)****	76,644	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 76,644	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliatio TAX RETURN NOT YET PREPARED**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,953	2,361	$ 53,679	$ 22.74	1
2	Assistant Director of Nursing	1,335	1,356	28,765	21.21	2
3	Registered Nurses	22,842	24,625	481,175	19.54	3
4	Licensed Practical Nurses	14,365	15,378	230,803	15.01	4
5	Nurse Aides & Orderlies	73,590	76,810	741,327	9.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,465	7,250	83,267	11.49	8
9	Activity Director	1,528	1,573	23,761	15.11	9
10	Activity Assistants	7,484	7,697	47,939	6.23	10
11	Social Service Workers	5,831	5,948	89,966	15.13	11
12	Dietician					12
13	Food Service Supervisor	1,928	1,946	29,064	14.94	13
14	Head Cook	4,309	4,707	46,538	9.89	14
15	Cook Helpers/Assistants	14,615	15,158	104,481	6.89	15
16	Dishwashers					16
17	Maintenance Workers	4,075	4,326	49,508	11.44	17
18	Housekeepers	26,627	28,111	189,920	6.76	18
19	Laundry	6,780	7,308	57,233	7.83	19
20	Administrator	1,816	2,080	60,597	29.13	20
21	Assistant Administrator	1,700	1,916	32,179	16.79	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,118	4,431	57,015	12.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,800	1,875	19,258	10.27	31
32	Other Health Care(specify)					32
33	Other(specify DIR OF MARK	668	710	9,385	13.22	33
34	TOTAL (lines 1 - 33)	203,829	215,566	$ 2,435,860 *	$ 11.30	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,500	1-3	35
36	Medical Director	O	4,000	9-3	36
37	Medical Records Consultant	N	1,246	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,350	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consulta	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,938	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL CONSULTANT		0	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 29,434		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NORA GORMAN	ADMIN	0.49%	$ 60,597
STEVE RUTAN	ASST ADMIN	0.00%	10,513
ERIKA BOCHNAK	ASST ADMIN	0.00%	9,433
KELLY TIGHE O'LERY	ASST ADMIN	0.00%	12,233
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,776

B. Administrative - Other

Description	Amount
CAREPLUS MGMT INC. - MANAGEMENT FEES	$ 154,000
HUNTER LLC - MANAGEMENT FEES	48,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 202,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CARE PLUS	DATA PROCESSING	$ 8,800
HDSI	DATA PROCESSING	2,707
AMERICAN DATA	DATA PROCESSING	3,452
CARE PLUS	ADMIN. CONSULTANT	148,500
KRUPNICK, BOKOR, KAGDA	ACCOUNTING FEES	19,350
MEYER MAGENCE	LEGAL FEES	12,856
ECONOCARE	PURCHASE CONSULT	2,741
PERSONNEL PLANNERS	UC CONSULTANT	2,480
RICHARD PEELO	MEDICARE CONSULTAN	3,750
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 204,636

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,166
Unemployment Compensation Insurance	35,296
FICA Taxes	185,251
Employee Health Insurance	82,706
Employee Meals	21,082
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	20,601
EMPLOYEE BENEFITS-OTHER	2,364
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 379,466

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	32,929
Health Care Worker Background Chec	637
(Indicate # of checks perform 53)	
ADV & PROMO/MARKETING	2,869
DUES & SUBSCRIPTIONS	7,305
LICENSES & PERMITS	1,220
TRUST FEES, CONTRIBUTIONS,etc.	445
MGMT CO ALLOCATION	1,247
LESS TRUST FEES, CONTRIB, etc.	(445)
Less: Public Relations Expense	( )
Non-allowable advertising	(2,812)
Yellow page advertising	(57)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,338

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
MGMT CO ALLOCATION	114
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 114

* Attach copy of IMRF notifications

**See instructions.